

From the Editor's desk

By Peter Tyrer

Youth, development and diagnosis

We remain in the contentious world of diagnosis in this issue, and the repercussions of the publication of DSM-5 can be heard clearly across the Atlantic.¹ Frances & Nardo (pp. 1–2) urge the World Health Organization in its ICD revision to be bolder and unafraid of deviating from its bigger American brother, and Koukopoulos *et al* (pp. 3–5) are at the forefront of kicking off this process in their review of the exact place of manic and depressive symptoms in classification, a subject with a long pedigree of debate in this *Journal* that still has a place in clinical practice.^{2–5} But there is an even thornier problem in the diagnostic thicket – the place of diagnosis in childhood. Over and over again we as clinicians are being asked to identify patients with every form of mental illness as early as possible – a classic example is the attempt to reduce the duration of untreated psychosis (DUP), still stubbornly remaining at varying periods averaging over 6 months despite all the efforts of early intervention teams (Birchwood *et al*, pp. 58–64) and others⁶ – yet at the same time being criticised repeatedly for misdiagnosing the normal perturbations of childhood with pejorative and potentially destructive labels that are clearly seen to be wrong in later life.^{7–9} The problem here is the dubious value of what should be a redundant piece of technology, the retrospectroscope. When one looks back at the psychiatric history of many young people with mental illness it is so common to yearn ‘why couldn't we have identified this problem sooner?’, yet at the same time forgetting that so many people with identical symptoms get completely better without any need for intervention. But if we fail to diagnose in childhood or adolescence, we cannot further develop studies such as the valuable one by Dogra *et al* (pp. 44–50), which shows differences in mental illness between ethnically White and Asian adolescents. These authors avoid possible criticisms of childhood diagnosis by coding mental illness covertly by a ‘mental health indicator’ derived from two questionnaires; but although this may be a useful general measure, we have no idea whether bipolar disorder and schizophrenia are less common in Asian adolescents or whether the differences are all linked to anxiety, depression and other common mental disorders.

Both the DSM-5 and future ICD-11 classifications are attempting to remove the artifice of having one set of diagnoses for childhood and another for adult life. This unnecessary doubling has to be removed; it adds to the already considerable problems experienced by clinical services in the transition between child and adult psychiatric services, as well as handicapping research. Old age psychiatry links much better to adult psychiatry (Sarró *et al*, pp. 51–57; Wetherell *et al*, pp. 65–72; Oude Voshaar, pp. 8–9) as diagnoses do not suddenly change when an age band is crossed. The present child–adult barrier is like one of those old border crossing points between West and East in the Cold War; it is confusing, unpleasant and hinders collaboration, and basically consists of territorial posturing. But if we are going to open up the borders between child and adult psychiatry, we need to have agreement on a common language. Child psychiatrists do

not like many of the adult psychiatric labels because they imply permanence or recurrence, so their immediate reaction is to reject them. But if we could regard almost all diagnoses as having a developmental aspect^{10,11} that allows for the possibility of resolution over time, this would be acceptable to everybody. The wording could be as simple as adding the adjectives ‘neuro-developmental’, ‘provisional’ or ‘putative’ before ‘disorder’ for each of our diagnoses, as I suspect adult as well as child psychiatrists would also feel it is more appropriate to allow proper acknowledgement of the high level of guesswork in psychiatric nosology. We could then reserve the definitive diagnoses for later when we have all our retrospectroscopes lined up and ready to show when we are right and when we are wrong.

Bill's view of the psychiatric world

Very few people are neutral in their feelings about William Jefferson Clinton, and I confess to being one of his fans. At the American Psychiatric Association in San Francisco in May we were treated to a bravura performance. It is just about possible for a major political figure, with the help of one or two scriptwriters, to give a sensible hour-long talk on mental health. But, apart from Bill Clinton, I know of nobody who could answer a series of spontaneous questions, from a sophisticated audience covering the range of psychiatry, for another 45 minutes with intelligent and informed answers. True, he did say in response to one question, ‘I have absolutely no idea’, but recovered himself and regrouped to answer in a form that would pass any postgraduate examination. He also pointed our direction towards the economic chasm awaiting us – as the average age of the population grows inexorably we will have to spend a great deal more on care, much of this on mental healthcare – and the political solutions we have been offered, in every country, are miniscule in proportion to the challenge. But ‘the last of the baby boomers’, as he entitled himself, is not one to give up easily, and there may be another Clinton initiative around the corner.

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